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Secretary Dempsey Benton
Department of Health and Human Services
2001 Mail Service Center
Raleigh, NC 27699-2001

Dear Secretary Benton,

I am writing regarding the recent occurrences at Cherry Hospital to express the concerns of the National Alliance on Mental Illness North Carolina, and to make recommendations regarding moving forward. Our organization very much appreciates the new energy you have brought to the challenges of reform, and the transparency with which you approach issues. We believe that it helps rebuild trust to share the full story, regardless of how badly that may reflect on the state employees involved. Because then people can together share their ideas for solving those problems. However, we are horrified, as we are sure you are as well, by the fact that the hospital abuses just keep happening.

Here are some of our recommendations that we are urging you to consider:

1. **Convene an outside, independent investigation.** Thank you for your openness in general in sharing how you are working on providing ongoing external management oversight for the next 90 days. We believe in general that the Department should routinely provide external, independent investigations, not just oversight. Further, why did it take so long to determine the gross negligence that occurred, when Mr. Sabock died in April? We must respond more quickly.
2. **Disciplinary Action.** The newspapers report that the investigation found that staff did not respond properly in at least two cases: the improper response to the teenager and of course the entire scenario with Mr. Sabock. It is someone's job to make sure that Mr. Sabock received nutrition. What the public, and people who live with mental illness want, is simple accountability: if people failed to perform their jobs, then they must be dealt with and fast. The committee you appointed on state psychiatric hospitals on which I served mentioned the importance of moving more rapidly to discharge staff when violations occur, and to make necessary changes in state personnel action and law to permit that. Families and people with mental illness who must use those state facilities need to trust that they will receive good care. I know you have commented that you are investigating what, if any disciplinary action will be taken. The "if any" part of that statement really concerns me: all of this is on videotape, and is well documented. I think swift action must be taken, within the next few days, as part of the rebuilding of the public trust. Let me add that I have just now read your press release statement, including information that workers were disciplined with punishments ranging from counseling to five days' suspension. Also they are removed from direct patient care for 60 days, and

must receive additional training. We totally agree with you that five days suspension for their part in a death is outrageous – it is grossly insufficient. This enrages the public to see the disciplinary action so out of proportion to what happened – a death.

3. **Administrative Oversight –** One item I negotiated to include in the report the earlier committee sent to you is to adopt the practice of administrative drop in supervision of all three shifts, and weekends and holidays. This would pertain to all top and middle managers. This is essential to developing a different work culture at all of our state hospitals. Administrators too often just work 8-5, and are not seen at other times by all the shifts. Yet they need to be seen in order to develop a team, and to stress the importance of 24/7 good care. Has that protocol been implemented, modeled after its success in the state MR Centers? If not, why not?
4. **Work Culture/Staff Training** – All of us question the training that all the workers receive, and its failure to achieve a positive work culture, one of respect for people living with a mental illness who are in a health care crisis. This must be reflected at all levels of staffing in the hospital. NAMI has a wonderful product called Provider Education Training, which applies to personnel at public agencies who work directly with individuals with severe mental illness. This course is held for l0 consecutive weeks, 3 hours per session, with 25-30 participants. It includes short lectures, group discussion, handouts and homework. It provides a penetrating subjective view of family and consumer experiences. It helps providers realize the hardships that families and consumers endure, and to appreciate their heroism in finding a way to reconstruct lives which must be lived "on the verge". This course is taught by 2 family members, 2 consumers, and one professional. Currently, NAMI NC does not teach this class (we do teach 5 others) but this seems so perfect for North Carolina, that I think we could work to bring in a team from South Carolina. This training, more than any other, could work to change the problems with the culture within our state hospitals. Changing how people behave (staff) would be one of the most important safeguards that we could add.
5. **Leadership Training –** Running an inpatient psychiatric hospital is a specialty field, and I wonder if the people we are recruiting have hospital administration credentials and experience. I would recommend that you consider a management company – that is used at Pitt Memorial Hospital, where you "buy" that particular expertise, while maintaining public operation of the state hospitals. Similarly, we would recommend that you consider contacting the administrators of our university affiliate hospitals for assistance, or for possible contract work.
6. **Independence of Advocates working for the state psychiatric hospitals** - I spoke to this problem on the committee you appointed me to, believing that it was not the right time to make so much change. But the ideal system is to have your advocates working for an independent entity, rather than for the state, so they can truly advocate without fear of losing their jobs. I think we need to revisit this in wake of these most recent developments.
7. **Dream Team addition at each state hospital** – I mentioned this idea to you just last week when we met briefly. I also gave material on this idea to Leza Wainwright and Flo Stein in a meeting I had with them perhaps a month and a half ago. The Dream Team is two individuals – a family member, and a person with a mental illness, placed in jobs at each state psychiatric hospital. Their role supplements that of social workers in the hospitals. They assist first time families in the initial intake process, from the perspective of having been there themselves. They help the family maintain hope that their lives can go on. They also provide psycho-educational training to those who are in the hospital for some time, or their families, which helps them learn about their illness, learn about recovery, and generally acquire coping skills. SAMSHA recognizes family psycho-educational programs as an evidenced based practice, along with disease and illness

management programs. Further, these individuals play a key role at discharge: they help with discharge planning, notify the family and the person of support groups, educational programs that may supplement the LME paid supports. And we all know that the discharge planning has been very problematic, with too many people, as many as 9%, going to shelters. At least they should be notified of these natural supports in a systematic way.

I would welcome the opportunity to work on getting any of these ideas going in North Carolina. I will look forward to hearing from you Secretary Benton.

Sincerely,

Debra G. Dihoff, MA
Executive Director

Cc: Leza Wainwright
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